OBLIGATIONS OF CHILD WELFARE WORKERS TOWARDS FOSTER CARE YOUTH INVOLVED IN DOMESTIC MINOR SEX TRAFFICKING: EXPANDING BEYOND IMMEDIATE SAFETY TO INCLUDE OVERALL WELL-BEING

By

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A thesis submitted to Johns Hopkins University in conformity with the requirements for the degree of Master of Bioethics

Baltimore, Maryland

May 2021

Abstract

The task of protecting foster care youth involved in domestic minor sex trafficking (DMST) falls on Child welfare workers (CWWs). CWWs are accountable for shielding youth from the dangers associated with continued involvement in DMST. This is an extremely challenging task because these youth regularly refuse to participate in mental health and substance abuse treatment and often run away from safe placements, thwarting the CWWs' attempts at rescue. When youth act in this self-defeating manner CWWs commonlly feel a strong responsibility to rescue the youth. After youths resist multiple attempts to extract them from DMST, CWWs are prone to conclude that they have only one option: to place these adolescent victims in locked residential treatment centers (RTCs) against their will. CWWs feel justified in this paternalistic approach because adolescents do not yet have full autonomy. Placing youth in locked RTCs meets the CWW's obligation to protect youth from the immediate dangers of DMST. Subsequently, CWWs relax, assuming that the RTC will provide for the youth's well-being.

Unfortunately, evidence suggests that youth remain at risk for sexual and physical violence even within the walls of RTCs. Moreover, providing personal security is not sufficient for the youth to achieve a state of well-being. RTC placement hinders the development of strong attachments with family, creates an environment where youth often feel disrespected, and fails to foster the development of autonomy. Autonomy development is of particular importance as one of the key psychological tasks of adolescence and a predictor of future well-being. I argue that before placing a youth in an RTC, CWWs should balance the youth's need for short-term safety with other needs including attachment, respect, and the development of autonomy. Taking into consideration all of these aspects of well-being, CWWs will discover that there are times when it is ethically permissible to allow youth to stay in the community. And

when youth are placed in locked RTCs, CWWs must advocate for everything that is owed to the youth to optimize well-being.

Primary Reader and Advisor: Travis Rieder

Secondary Reader: Rebecca Seltzer

Acknowledgements

I wish to express my deepest gratitude towards Travis Rieder who has been an encouragement throughout my course of study. Dr. Rieder provided feedback that elevated my critical thinking and writing skills in a way that was encouraging and empowering. I also appreciate all of my teachers throughout my training. Each contributed to my understanding of bioethics and challenged me to think critically about many issues. In particular, Anne Barnhill taught a variety of courses that expanded my knowledge about social justice as well as how to make comprehensive arguments. Caitlynn Kennedy has been an invaluable resource about qualitative research techniques, and she has consistently provided her expertise when I have asked for it. I also have leaned an incredible amount from all the peers I worked with during my course of study. My agraphia group was particularly instrumental in my success.

This thesis would not be possible without the opportunity to consult with Baltimore City Department of Social Services. The inspiration for this thesis were inspired by the unsung heroes working with youth in foster care. Every day these workers labor to provide for the safety of youth in foster care, often under conditions that do not afford any acceptable options.

Finally, I am indebted to my mother, Dorothy Barnett, my sister-in-law Jeannie Kahwajy, and my husband Kevin Kahwajy for all of your editorial suggestions that have elevated my writing abilities.

Dedication

In loving memory of my father, David Barnett and with gratitude to my mother, Dorothy Barnett for their never-ending love and support throughout each phase of my education.

To my amazing husband Kevin, I appreciate your love, understanding, and support during my pursuit of this master's degree. And finally, for my wonderful children Justin and Kylie for your cheerleading, love, and patience as I worked through my degree program. I will forever cherish this past year where we all attended school together from home due to the COVID-19 pandemic.

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Introduction

Definition and Scope of the Problem:

Society's most vulnerable youth are the most likely to be entrapped in domestic minor sex trafficking (DMST). In 2000, the United States government acted to protect these youth by passing the Victims of Trafficking and Violence Protection Act (Smith, 2000). This act requires that the legal system consider youths involved in commercial sex acts as victims as opposed to delinquents. It defines a commercial sex act as "any sex act on account of which anything of value is given to or received by any person" (Smith, 2000). Commercial sex acts include sex acts performed for food, clothing, or shelter (often called survival sex), sex acts where the youth directly receives compensation for the sex act, or sex acts where a third party (a pimp or significant other) receives financial compensation. The states' obligation to protect youth was further expanded in 2014 by the passing of the Prevention Sex Trafficking and Strengthening Families Act (PSTSFA) (Camp, 2014) which requires that states take steps to identify and protect all youth at risk of being trafficked. Once identified, many of these youth are placed into state custody to be cared for and protected by the foster care system (Fong & Berger-Cardoso, 2010). While these youth are in foster care, child welfare workers (CWWs) are responsible for the safety and well-being of these youths.

Another mandate of the PSTSFA requires that states protect all youth living in the foster care system from the dangers of DMST. It recognizes that youth in foster care are particularly vulnerable to recruitment into DMST. This vulnerability is the consequence of traumatic histories coupled with frequent placement disruptions that are common to many youths in foster care (Fong & Berger-Cardoso, 2010). The PSTSFA requires that child welfare agencies screen youth for possible DMST involvement and act to protect them. The upside of these screenings is that CWWs identify the most vulnerable youth. The downside is that CWWs are then

obligated to protect these vulnerable youth despite the fact that no intervention has been proven to shield youth from the dangers of DMST. As a result, CWWs are working to protect youth within the confines of limited placement resource options, none of which are designed or proven to protect youth from the dangers of DMST.

The placement options for foster care youth involved in DMST are no different from the options for other youth in foster care. The vast majority (approximately 78%) of the over 400,000 youth in state custody reside in foster homes with either relatives or non-relatives (Child Welfare, 2020). Another 2% of youth in foster care reside in an independent living program. These programs allow older youth to live on their own, but provide frequent contact with staff to help support the youth's independence. However, foster homes and independent living programs are often unavailable to youth involved in DMST. Relatives, foster parents, and independent living programs feel ill-equipped to keep youth who engage in dangerous activities such as DMST. Therefore, many of these youth are more likely to end up living in a group home or more restrictive placement (Farmer et al., 2015). Data from 2018 (the most recent data available) shows that 4% of youth in foster care live in group homes (Child Welfare, 2020). The term group home encompasses a wide variety of group residential placements. These homes are generally located within the community and youth are often allowed to visit friends and family with varying degrees of freedom. Like youth living in foster homes, these youth attend school, work, and receive mental health services in the community.

Youths are placed in residential treatment centers (RTCs) when the state, in concert with recommendations from licensed mental health workers, determine that a youth cannot be safely maintained in the community. Approximately 6% of youth in state custody reside in institutional settings such as RTCs (Child Welfare, 2020). RTCs are licensed mental health programs where youth live, receive mental health treatment, and attend school all on one campus. Typically, youth who reside in an RTC are under constant supervision by staff and only leave

the campus under the supervision of staff or for short visits to family. The constant supervision provided to youth placed in an RTC provides comfort to CWWs working with youth involved in DMST, as these programs meet the function of protecting youth from DMST. However, before placement, CWWs must understand and consider the impact of an RTC placement for youth involved in DMST. I hope to provide CWWs with information to guide placement decisions and the skills to mitigate the negative impacts that are associated with the final placement choice.

Illustrative Cases

Marjory's aunt/ kinship care foster parent calls Marjory's Child Welfare Worker (CWW) Ms. Simms. Marjory, who is only 12 years old, snuck out of the home again last night. Marjory insists that she just hangs out with friends. However, the local police have contacted Ms. Simms because they have footage of Marjory in several hotels with a suspected sex trafficker. Marjory's aunt and Ms. Simms are terrified thinking about what might happen if Marjory stays in the community. They are relieved when Marjory is admitted to a locked residential treatment center (RTC) because they know that she will not be out on the streets engaging in domestic minor sex trafficking (DMST).

Ciara calls her CWW Ms. Jansen in tears begging to be placed in a foster home. Ms. Jansen is relieved to hear from Ciara. Ciara ran away from her most recent placement five weeks ago and almost certainly returned to sex trafficking to support herself. Ms. Jansen worries that Ciara will run away and return to sex trafficking if she is placed into foster care. After all, Ciara has run away from the past six foster homes within days of placement. Ms. Jansen believes that Ciara will be in danger until she is placed in a locked RTC. In a few months, Ciara will turn 18. After her birthday, Ciara would have to agree to an RTC placement before she could be admitted. Ciara reminds Ms. Jansen that she has been placed in two different RTCs over the past three years and Ciara did not find these placements beneficial.

Nevertheless, Ms. Jansen feels obligated to protect Ciara from the dangers of DMST, and therefore she does not believe she has other options.

Both of the above CWWs are using a protectionist model which emphasizes their obligation to provide safety (Raghaven & Alexandrova, 2015). Qualitative interviews show that CWWs prioritize safety and often believe that they will be liable for any bad outcomes (Armaline, 2005). Prioritizing immediate safety leads CWWs to conclude that youth engaged in DMST must be placed in locked RTCs. After all, this is the only way to guarantee that the youth will not return to their trafficker.

There is no doubt that CWWs are obligated to protect youth and keep them safe. However, I argue that CWWs have an obligation that goes beyond safety and extends to the complete well-being of the youth. Well-being is a construct that encompasses an individual's subjective perception that his or her life is going well (CDC, 2018). Individuals differ on what they need to experience well-being. However, many experts agree on several universal conditions for well-being. These conditions include personal security, access to healthcare, significant attachments, respect, and autonomy (Faden and Powers 2006; Peterson, Zhou, and Watzlaf, 2019; CDC, 2018; Kobau et al., 2010). Autonomy development is an essential task of adolescence and thus particularly relevant to youth involved in DMST (Barnett, 2019; Spear and Kulbok, 2004). Unfortunately, youth involved in DMST have many risk factors that obstruct autonomy development. These risk factors include trauma histories, poor attachments, and limited opportunities to practice autonomy (Barnett, 2019).

I aim to demonstrate the importance of promoting well-being in youth involved with DMST. Moreover, I want to empower CWWs to optimize well-being in youth regardless of their placement. In order to meet these goals, I will first examine the immediate threats to safety faced by youth involved in DMST. Understandably, CWWs recognizing these threats tend to seek placement in an RTC where youth are removed from DMST. Nevertheless, I will provide

evidence demonstrating that an RTC admission prioritizes immediate safety at the detriment to other aspects of well-being, particularly autonomy development. My intent is not to cause despair, but to draw attention to the tension between providing short-term safety and making available the necessary environment for long-term well-being. An understanding of youth's unmet needs should be met with strategies to overcome these deficits. Because I believe that autonomy development is a fundamental developmental task during adolescence and is also crucial to well-being, I will take time to review normal autonomy development and then highlight barriers to autonomy development frequently encountered by youth involved in DMST. I will use a knowledge of well-being and autonomy development to propose concrete interventions that CWWs can use to promote the well-being of youth in foster care who are involved in DMST, whether the youth is admitted to an RTC or stays in the community.

Obligation Owed to Youth Involved in Domestic Minor Sex Trafficking

Dangers Associated with Domestic Minor Sex Trafficking

A CWWs urge to remove youth from DMST and place them in an RTC stems from a legitimate concern for the youths' safety and well-being. The negative impacts of DMST are undeniable. High rates of pregnancy, sexually transmitted infections, and emotional behavioral problems are found in these youth (Todres and Clayton 2014, Varma et al. 2015). Especially concerning is the risk of acquiring HIV, hepatitis, and Herpes, as well as increased exposure to HPV and the risk of later developing cervical cancer. Substance use also carries the risk of overdose and liver disease due to chronic alcohol use. The high levels of stress and trauma associate with DMST predispose youth to many chronic medical and mental health disorders, including higher rates of coronary artery disease, type 2 diabetes mellitus, depression, and post-traumatic stress disorder (Bradshaw et al, 2012).

Additionally, youth who are involved in DMST often have significant behavioral dysregulation that make it difficult to maintain these youth in the community. These youth often engage in violence, are disrespectful to caregivers, use illicit substances, and run away from placements, leaving caregivers feeling powerless (Todres and Clayton 2014, Varma et al. 2015).

These negative behaviors interfere with building positive relationships between youth and caregivers, leaving youth vulnerable to predators who recruit youth into DMST by posing as attractive attachment figures. Traffickers groom youth by paying attention to youth and establishing trust (Bounds, 2015). Traffickers often take on the role of a parent or pose as a romantic partner before introducing youth to DMST (Polaris, 2015). The trafficker may be a youth's strongest attachment figure and youth often trust traffickers over CWWs. One study found that less than half of DMST youth interviewed acknowledged that their pimp or trafficker was not acting in their best interest (Westcoast Children's Clinic Research in Actions, 2012). When a trafficker is the youth's strongest attachment figure, it can be very difficult for CWWs to convince youth that their trafficker does not have their best interest at heart, a necessary condition for convincing youth to avoid the trafficker.

These risks of DMST can be terrifying for both CWWs and foster parents. Foster parents often ask for the removal of youth because of fears they will be liable for negative outcomes. Caregivers argue that the youth should be placed somewhere that is better able to meet the youth's needs, implying that such a place exists.

Obligations of Child Welfare Workers

Clearly the risks of DMST involvement warrant adult intervention to protect these youth and provide an environment that fosters well-being. Ideally, this responsibility would fall on parents who bear the bulk of the responsibility of raising youth. Parents have a "moral responsibility for ensuring their [child's] survival and development and preparing them for

citizenship in a liberal society" (Engster, 2010). This moral responsibility extends both to the child in the present and also to the child's future adult self (Raghavan & Alexandrova, 2015).

Unfortunately, most youth involved in DMST cannot rely on parents to shield them from the risks associated with DMST. In these cases, the state is obligated to step in and protect these youth. Youth may be placed into state custody after DMST involvement is discovered, or youth may be recruited into DMST from foster care. In either case, most youth involved in DMST spend a portion of adolescents in the foster care system (Landers et al., 2017). When youth enter foster care, parental obligations shift to the state. While the state certainly has the obligation to protect youth from physical dangers, CWWs might wonder if their obligation extends to providing total well-being. Wulczyn, Parolini & Huhr (2018) acknowledge that all children have a right to well-being. However, they worry about burdening CWWs with obligations which they are not equipped to provide. While the CWW may not be the direct actor to provide every aspect of well-being, I argue that the CWW must understand what is required for youth to experience well-being. CWWs are obligated to use this knowledge to maximize the youth's well-being. Understanding the factors that contribute to well-being will equip CWWs to determine whether an RTC placement is most suitable for a given youth. In addition, CWWs will be better prepared to provide opportunities to enhance well-being no matter where the youth is placed.

Impact of Residential Treatment Centers on Well-being

CWWs assume that locked RTCs will keep the youth safe. Unfortunately, RTC placement does not guarantee freedom from physical and sexual assaults. The histories of trauma and poor attachment that make youth vulnerable to DMST also make them vulnerable to abuse by staff and peers. The extent of abuse by staff and peers is unknown, as much of it goes unreported. The most thorough review of abuse was undertaken by the United States

Government Accountability Office in 2007 where they found over 1500 allegations of abuse in 33 states in the year 2005. These acts include physical abuse and sexual abuse, some resulting in death (United States Government Accountability Office, 2007). While there is no recent large review of abuse rates in RTCs, youth in residential facilities continue to accuse staff of abuse (AP, 2021; Mooney, 2021).

CWWs might expect that locked RTCs provide the treatment youth need to heal from their past traumas and give them the skills needed to avoid returning to DMST after discharge. Unfortunately, there is little evidence demonstrating a benefit of RTC treatment for youth with severe emotional behavioral disorders. No studies have demonstrated a significant benefit of treatment in an RTC over community care. A few studies have found some short-term improvements of youth at discharge as compared to baseline (Shapiro, Welker, & Pierce, 1999; Leichtman, Leichtman, Barber & Neese, 2001; Lyons, Terry, Martinovich, Peterson & Bouska 2001). However, over the long term, youth placed in RTCs have poorer outcomes in mental health, delinquency, and homelessness (Barth, 2002; Hair, 2005; Embry, Step, Evans, Ryan & Pollock, 2000). Furthermore, there is no evidence that RTC placement prevents youth from returning to DMST.

By nature, placement in an RTC program impedes attachment to family members and other long-term attachment figures in the community. Youth involved in DMST are often placed far from their family in an attempt to separate them from their trafficker. An unintended consequence is that family members cannot visit frequently. RTCs often have strict visiting and phone hours, further restricting youths' access to family. Treatment in an RTC may also limit the frequency of family therapy sessions. In some RTCs, therapists work hours 9-5 on weekdays. And when family members are available for family therapy, there is no guarantee that the therapist at the treatment facility has expertise in attachment work.

Respect for youth is often lacking in RTCs. Many RTCs have restrictive behavioral systems. These systems focus on the youth's behavior. When youth misbehave, staff often respond by pointing out the negative consequences of the youth's behavior and fail to notice positive attributes (Stanley, 2016). These interactions are often pejorative. Staff may label youth as manipulative, attention-seeking, or unempathetic. Placing these labels on youth can dehumanize youth in the eyes of staff members, leading to staff treating youth in very disrespectful ways.

When deciding whether to place a youth in an RTC, CWWs should consider the impact of this type of placement on the development of autonomy. I plan to show that foster care youth involved in DMST routinely miss out on factors that facilitate autonomy development. Placement in an RTC further erodes opportunities to develop autonomy. This is unfortunate, as studies demonstrate and association between autonomy development and positive outcomes in education, social relationships, and employment (Soenens & Vansteenkist, 2005). These same outcomes often elude youth who age out of foster care (Naccarto & DeLorenzo, 2008; Rome, 2019).

Each of these above conditions, ongoing trauma, poor attachments, and frequent disrespect, all place youth at a disadvantage when it comes to developing autonomy. In addition, youth in RTCs have few opportunities to practice autonomy. Taken together, youths living in an RTCs may not fully develop autonomy.

Development of Autonomy

Before a CWW can develop strategies to optimize the well-being of youth involved in DMST, it is important to take a step back and review normal autonomy development. This understanding will help CWWs recognize the many challenges to autonomy development facing

these youth and motivate CWWs to intervene in ways that mitigate the adverse effects of DMST on the development of autonomy.

Definition of Autonomy

Autonomy is a psychological construct that at its core embodies the personal experience of self-governance. Czerwinska-Jasiewcy (2017) describes autonomy as "[t]he creation of a concept of [one's] own life". Sokol et al (2015) describe the phenomena of "personal meaning making that is integrated with self-control over the lifespan."

The concept of autonomy is sometimes partitioned into cognitive autonomy (or rationalization) and behavioral autonomy (or self-determination) (Parra & Oliva 2009). Cognitive autonomy refers to the experience that one is in control of one's own life. An autonomous individual ascribes to a specific and personalized hierarchy of core values that remain stable over time and across a variety of situations. Autonomous individuals consider both short-term desires and long-term values when choosing a course of action (Sokel et al).

Behavioral autonomy refers to the ability to make one's own decisions. Behavioral autonomy requires emotion regulation skills that can be employed to override immediate urges and avoid tempting situations that can thwart long-term goals (Converse et al., 2019). Behavioral autonomy also requires decision-making skills. Youth learn decision-making skills by gradually practicing making small decisions under the supervision of trusted adults who are available to support them when things do not go as they hoped.

In addition to decision-making skills, behavioral autonomy requires that individuals have access to an environment which allows them to reach their individual goals. Restricted educational opportunities, limited access to recreational activities, racial discrimination, and limitations on who they are allowed to visit can block a youth's autonomy. For example, a youth who wants to repair a relationship with a parent would require a way to contact that parent, permission to contact that parent, support through the difficult process of reconciliation, and

another adult offering support and encouragement to the parent to help that parent receive the youth's efforts for reconciliation.

Normal Development of Autonomy:

Cognitive and behavioral autonomy both develop in concert throughout childhood and adolescence (Barnett, 2019). Caregivers facilitate the development of autonomy by providing youth with: 1) a stable and caring relationship that helps youth tolerate distress and delay gratification; 2) support and encouragement to develop stable goals, and 3) opportunities to experiment and take appropriate risks (Mulin, 2014). Additionally, parents aid the development of autonomy by helping the youth cope with failures (Zimmerman & Cleary). Parents with high levels of expressed warmth, appropriately high levels of control, and who provide opportunities for youth to make age-appropriate choices about short and long-term goals are best poised to optimize autonomy development (Niemiec et al., 2010).

While autonomy matures in adolescents, early life experiences impact the development of autonomy. During infancy, a safe and predictable environment allows babies to develop preferences for particular caregivers and caregiver responses (Mulin, 2014; Sokol et al., 2015). Behavioral autonomy begins as young children become more mobile and explore the world, returning frequently to a caregiver for reassurance and comfort (Minow & Shanley, 1996). As they explore, young children require external controls to keep them safe from acting on impulses. Young children rely on caregivers to comfort them during times of distress, but secure attachments allow youth to gradually internalize these efforts and develop emotion regulation skills (Schofield & Beak, 2005).

Of course, while young children are able to form preferences and goals, they do not yet possess the capacity to understand the long-term consequences of decisions or to predict accurately what they will find meaningful as adults (Mulin, 2014). Children's future selves rely on adults to place restrictions on their choices. Young children frequently lack the self-control necessary to delay gratification or tolerate a painful or boring event in the pursuit of a desired

outcome (Mulin, 2014). Children begin to develop the capacity to suppress behavioral urges around ages 8-9 years (Niemiec et al., 2010). This gradual shift from external motivators to internal motivators is necessary to develop into an autonomous individual (Converse & Juarez, 2019).

During adolescence, supportive caregivers who validate the youth as a separate individual facilitate the youth's development of a strong sense of self. Caring adults support the youth's development of an internal hierarchy of values (McElhaney et al., 2009). Youth can take advantage of external motivators for reaching long-term goals without obstructing the development of autonomy, under the condition that the youth incorporates these outside influences into their personal narrative regarding core values.

Adolescents with strong attachments to caregivers are able to navigate the world on their own much of the time, but also feel comfortable seeking support from the caregiver when needed (McElhaney et al., 2009). However, they frequently fail to grasp the dangers associated with the pursuit of more immediate desires, including minimizing the risks of substance use and sexual activity (Mulin, 2014). As adolescents develop a cognitive understanding of particular risks, they are prone to assigning greater value to social rewards which often eclipse potential dangers or minimize the importance of realizing their long-term goals (Pfeifer & Berkman, 2018). Therefore, caregivers aid adolescents as they pursue long-term goals by providing feedback and encouraging youth to make appropriate decisions, while also providing restrictions when necessary (Niemiec et al., 2010).

Autonomy Development in Youth Engaged in DMST

The environment that normally fosters the development of autonomy is often tremendously different from the reality of youth involved in DMST. The following section reviews the many barriers to autonomy development that are common place for youth involved in DMST. Once I review the myriad of obstacles preventing autonomy development in youth

involved in DMST, I will then be able to provide CWWs with a list of interventions that target these particular deficits.

What Hinders Autonomy Development

Youth involved in DMST face multiple barriers to autonomy development, including trauma histories, poor attachment to caregivers, and the realities of foster care. Involvement in DMST is commonly proceeded by a history of physical and sexual abuse, previous exposure to sex trafficking, poor attachment to adult caregivers, and/ or rejection by their family members because of their sexual orientation (Cecchet and Thoburn 2014; US Department of State, 2016). Once youth are involved in DMST, they are constantly vulnerable to further trauma.

Additionally, an avoidant or insecure attachment style is common among youth in foster care (Miranda et al., 2015). Avoidant attachment includes a lack of trust in others and a desire to control others. The self-defeating behaviors of youth involved in DMST such as running away, continued involvement in DMST, not attending school, using illicit substances, and avoiding mental health treatment further impede the development of strong attachments. CWWs and other caregivers may react to these youth with a variety of reactions, including a wish to save the youth, a wish to punish or reject the youth, or a wish to give in to the youth's demands (Roberts, Geppert, & Bailey, 2002). These wishes make it very hard to treat the youth with respect. When CWWs and other caregivers do not treat youth with respect, it is harder to develop positive attachments with youth or to encourage the youth's development of autonomy.

Development of Internal Goals and Values

Without a secure attachment figure, youth may struggle as they explore the world without adults who can help them form a coherent and stable sense of self (Schechter & Willheim, 2009). This means that many youths in foster care find it difficult to develop a coherent set of values and goals, let alone imagine a future that includes achieving these goals.

Youths who do not trust caregivers become resistant to feedback from caregivers and therefore cannot benefit from discussions about future goals with caregivers (Schofield & Beek, 2005).

The absence of a secure attachment figure may result in a youth developing goals that run counter to the youth's overall best interest (Abrams, 1999). Youth may want to avoid the control of authority figures, escape anxiety-provoking situations, regain control of meeting their material needs or maintain a relationship with their trafficker. These goals run counter to the youth's immediate safety and do not foster the development of long-term goals.

Development of Emotion Regulation Skills:

Early trauma can lead to emotional and behavioral dysregulation as well as mental disorders that predispose youth to engage in DMST. Involvement in DMST then worsens pre-existing mental disorders and intensifies emotional and behavioral dysregulation (Ehring & Quack, 2010; Palines et al., 2020). Trauma inhibits the development of emotion regulation skills. Without effective emotion regulation skills, youth often feel that their actions are driven by emotions as opposed to an internal set of values and goals (Jankowska et al., 2015). While youth experience an external locus of control for their own behavior, previously abused youth often feel responsible for the actions of their caregivers. Abused youth often believe (and are often told) that if they behave in a certain way they will not be abused or that they will be reunited with their parents. This sense of responsibility can develop into a belief that the youth can control caregivers (Zimmerman & Cleary, 2006). This flipped belief that the youth is responsible for the behavior of caregivers while simultaneously feeling unable to control their own behavior can lead to continued engagement in dangerous behavior (Philosophicaltherapist, 2017).

Disrupted or absent attachments also inhibit the development of adaptive emotion regulation skills (Faden and Powers, 2006; Kim & Cicchetti, 2010; Olender, 2019). Morris et al. (2007) developed a tripartite model that demonstrates that children develop emotion regulation

skills by observing parents using emotion regulation skills, by parents coaching children in the use of emotion regulation skills, and through a secure attachment to parents. Youth in foster care, therefore, have limited access to each component of this tripartite model, and therefore their development of emotion regulation skills may be compromised. Without adaptive emotion regulation skills, youth are more likely to react to negative stimuli without regard to how that reaction may affect their future. For example, a youth may be in a safe foster home when a foster parent says something that inadvertently reminds the youth of previous trauma. That youth may feel overwhelmed with extreme anxiety so she runs away in an attempt to escape these emotions. Once she runs away she needs food and shelter so she returns to sex trafficking even though this activity has a higher risk when compared to returning to her foster home.

Opportunities to Practice Autonomy:

Youth in foster care have fewer opportunities to practice making autonomous decisions compared to youth who are not in care. Studies show that even young children have opinions about which relationships are important and should continue while they are in foster care (Schofield, 2005). Yet, most youth in foster care report feeling that important decisions are made about them, without their input (Polkki et al 2012). When they are asked to provide input, they worry about making the "right decision" (meaning the decision that would make the adults happy) and do not feel well-coached as to how they could provide input (Leeson, 2007). Furthermore, youth in foster care are less likely to express their opinions about family rules and activities when compared to biological children (Singer et al., 2004). Without opportunities to express their opinions, it is difficult for them to develop an internalized set of goals and values.

As foster care youth become older, they experience fewer opportunities to practice autonomy compared with peers who are not in foster care. Intending to protect vulnerable youth, child welfare agencies often restrict a youth's ability to spend time with friends. Many social service agencies restrict youth from spending the night at friends' homes unless the

agency verifies that the home is appropriate. Youth in care may miss out on employment opportunities if they do not have a copy of their birth certificate or other paperwork that is necessary for obtaining an ID. Youth living in group homes or independent living programs may not have opportunities to learn to drive a car.

One frequently missed opportunity to practice autonomy occurs in the context of healthcare decisions. Adolescents living with parents gradually take on responsibility for healthcare decisions under the support and guidance of trusted caregivers. However, while adolescents involved in DMST are likely to have multiple health needs, they are often excluded from healthcare decisions. Child Welfare systems are often set up so that CWWs, their supervisors, or even court-appointed lawyers are the ultimate decision-makers (Strassburger, 2016). This means that the youth are not actively participating in decisions regarding their health and mental health care, missing out on opportunities to practice autonomy.

Moreover, adolescents with trauma histories are frequently distrustful of new caregivers and attempt to exert control when entering a new placement. Foster parents often label these attempts to exert control as oppositional, and they respond by limiting opportunities for youth to practice autonomy (Schofield & Beek, 2005).

Autonomy requires that youth have the power to carry through with their chosen plan of action. Youth involved in DMST are often in positions of limited power. These youth are often members of racial minorities, yet most buyers are white cisgender males ages 30-50 (Rozas. Ostrander, & Feely, 2018). In these interactions, the buyers hold much of the power. Experiences where youth experience little power can squelch the development of autonomy.

Interventions to Increase Well-being

Interventions for Youth Referred to Residential Treatment Centers

After balancing the risks of keeping the youth in the community against the risks of admitting the youth to an RTC, there may be times that a CWW decides a youth is best served

in an RTC. Youth may be admitted to a locked RTC when the risks of keeping the youth in the community are too high or the youth is too emotionally dysregulated to be safely maintained in the community. Youth also occasionally request admission to a locked facility when they are afraid of their trafficker (Walker & Quraishi, 2014). Once a CWW determines a youth will be placed in an RTC, the CWW must continue to identify and respond to threats to the youth's well-being. CWWs can use an understanding of well-being, and particularly an understanding of autonomy development, to come up with a comprehensive strategy to addresses all aspects of well-being.

CWWs have a duty to take steps to minimize the possibility that the youth will suffer from abuse while in an RTC. Prior to admission, CWWs should investigate potential programs to guarantee that the program is fully accredited and that there are no creditable allegations of abuse made by youth in the facility. CWWs should ask the programs administrative staff to describe protocols and staff trainings aimed at minimizing the risk that staff and other patients will assault youth. Additionally, CWWS ought to inquire about the number of abuse allegations by staff over the past several years and ask about the protocol response when a youth makes allegations. Before a youth is admitted to a treatment facility, the CWW should talk with that youth about behaviors that might indicate a risk of assault (including grooming behaviors) and invite the youth to disclose all concerns. If a youth does voice concerns, it is important that CWWs take these concerns seriously and not assume that the youth is making up the complaints.

Close attachments are vital to providing well-being. Yet, RTCs often restrict opportunities for youth to visit with or talk with family. CWWs must advocate for youth to have frequent opportunities for both in person and phone contact. Whenever possible, youth should visit parents on a regular basis, as home visits predict improved outcomes (Huefner et al., 2014). CWWs should also work with family members to identify and overcome barriers to

visiting youth. This might mean providing transportation or advocating against restrictive visiting hours.

CWWs should not assume that RTC programs are providing the most appropriate mental health services for a particular youth. Therapists may not be trained in treatments that have shown promise for youth involved in DMST. Promising treatment models for youth involved in DMST focus on building relationships, reframing behavior as a trauma response, and emphasizing the empowerment of youth (Gewirtz et al, 2020; Diaz et al, 2020; Welch, 2020). CWWs should advocate for youth to receive both individual and family therapy. Ideally, therapists will be well versed in trauma treatment and attachment work.

CWWs should be aware that youth who are suffering from trauma, emotional, and behavioral disorders often feel disrespected. CWWs should make a deliberate effort to offer the youth respect during every interaction. Talking with the youth about his or her strengths, opinions, and goals demonstrates respect. Validating the youth's experiences and frustrations also shows respect. Finally, CWWs should advocate for youth when there are concerns that the youth feels disrespected by the RTC staff. Sometimes the CWW may have to demand discharge if a youth feels consistently disrespected by staff.

Because RTCs limit opportunities for youth to practice autonomy, CWWs need to be creative to provide opportunities for youth to make choices and decisions. Whenever possible, CWWs should encourage youth to express goals and preferences. Youth should be allowed to choose the family members who will visit and participate in family therapy. Youth can also provide input into how they decorate their room, the type of clothes they wear, and the activities in which they engage. When CWWs visit, the youth should be given opportunities to choose activities. Medication decisions are another great occasion for youth to practice autonomy. CWWs should actively engage youth in discussions regarding medication changes, allowing youth to verbalize preferences. Finally, everyone should prioritize returning the youth to the

community where there are more opportunities to practice autonomy. The CWW should encourage staff to determine a plan for how to get the youth discharged to the community as quickly as possible.

Interventions for Youth who Remain in the Community

An awareness of the negative impact that RTC placements have on well-being in general, and on autonomy development in particular, may lead CWWs to conclude that some youth would be best served within the community. Community placements include group homes, relative placements, foster homes, or supervised independent living programs. Fortunately, community placements do not resign youth to a life involved with DMST and trauma. CWWs can use knowledge about well-being, with particular attention to the development of autonomy, to devise interventions to reduce risk to the youth and improve the youth's well-being.

CWWs caring for youth involved in DMST in the community may feel powerless to provide personal safety. It is beneficial to realize that CWWs typically work under a normative model of trying to move youth from risk to resilience (Schwarz et al., 2015). This model assumes that youth are receptive to rescuing. There are other models that CWWs can consider. For example, CWWs can borrow aspects of queer theory that emphasize a non-judgmental stance and a need to continually offer services that youth are free to either accept or decline. This theoretical model also recommends that CWWs assume youth will go back and forth between a state of willingness to accept help and resistance to help. Youth who are not ready to admit that they need help benefit from CWWs (and ideally placements) that will welcome them back without judgment (Walker & Quraishi).

Of course, youth who stay in the community are at increased risk for physical and sexual trauma (Todres and Clayton 2014; Varma et al., 2015). Fortunately, there are many approaches available to CWWs that will reduce risk. CWWs should work with youth to come up

with strategies for youth to feel safe in new and unfamiliar placements. This might include providing youth with calming objects and a safe space. If youths are running away in response to events that trigger trauma reactions, CWWs can help youth identify these triggers and develop strategies to minimize exposure. For example, there may be certain phrases that remind the youth of a previous abuser. The CWW can help talk with the caregiver to make the caregiver aware of the need to avoid those phrases. CWWs can also help youth brainstorm safe places for the youth to go when they run away and encourage youth to identify safe adults to contact. The goal should be to encourage youth to return to a safe placement quickly as opposed to expect youth to never run away. When youth return, CWWs should welcome youth back as opposed to scolding youth for running away or lecturing youth on the dangers of running away.

CWWs can also help youth stay safe by encouraging them to always carry a charged cell phone. Sometimes CWWs are reluctant to allow youth to have cell phones because they do not want the youth's trafficker to have a way to contact the youth. However, CWWs can use technology to limit how the youth can use the phone. Additionally, an active cell phone plan is not necessary for calling 911. At a minimum, youth should be encouraged to carry a phone that can be used to call 911. CWWs can also inform youth about resources in the community that might be beneficial for youth involved in DMST.

CWWs have many opportunities to improve the health of youth involved in DMST. They should make sure that all foster care youth receive sex education that can empower them to prevent sexually transmitted infections. When a youth with suspected DMST involvement is placed in the community, the CWWs should consider providing youth with condoms. Female youth should be offered birth control in a way that is supportive and non-judgmental. CWWs should also encourage youth to monitor for signs of sexually transmitted infections and get tested regularly.

Youth who are involved in DMST often have difficulty keeping scheduled appointments, as they tend to stay away from home during the day and frequently run away. CWWs should identify clinics that are willing to see youth on a walk-in basis so that the youth's healthcare needs can be met during the moments that the youth is willing and available to seek health care.

Trauma histories predispose most youth involved in DMST to develop mental health problems. Yet, youth are often reluctant to participate in mental health treatment. Many youths experience mental health treatment as ineffective and sometimes harmful (Lee, 2006). Youth complain of clinicians who do not listen to them and side with adults (sometimes even the abuser) over the youth. Mental health treatment identifies the youth as the problem that needs fixing, as opposed to placing blame on what has happened to the youth. The prescription of psychotropic medication also often signals to the youth that they are damaged or defective and gives the power of behavior change to a pill (Pope, 2015).

When youth do not readily attend or participate in mental health treatment, CWWs should ask youth about their previous experiences with mental health providers. Acknowledging and validating any negative experiences can let youth know that many youths have had similar complaints. The mental health system should not be adding to a youth's stress. CWWs should also ask if youth have had any positive experiences with mental health professionals and ask what made those interactions helpful. Youth seek relationships with mental health providers that are safe, where youth do not feel judged, and where they can partner with the therapist to overcome their past (Ladd & Weaver, 2018; Walker & Quraishi, 2014). CWWs may need to work with youth to reframe what it means to be in mental health. Mental health treatment should help youth overcome past traumas, repair relationships, and empower a person to take control of their present and future.

If youth are willing to participate in mental health treatment but struggle to attend appointments, CWWs can help identify barriers to attendance in a way that does not blame youth but rather acknowledges real barriers to treatment. If youth have difficulty sticking with a schedule and are often unavailable when it is time for their therapy, they may benefit from apps that teach mindfulness skills. Youth who have had bad experiences with mental health treatment might be more amenable to alternative therapies such as biofeedback, art therapy, or equine therapy. Youth who use illicit substances may benefit from SA treatment or motivational interviewing to help them realize that they need substance use treatment.

Interviews with youth in foster care emphasize the need for long-term relationships with adults who show that they care for the youth every day (Holland, 2010). Ideally, this will be a family member or other adult from the youth's life. If there is no identified adult, it is important to find the youth a mentor or other adult who can commit to a long-term relationship with the youth.

Once attachment figures are identified, the CWW should work with that person to help them understand the importance of their role and provide education and coaching as to how that adult can facilitate attachment. While this would ideally occur with help from the youth's mental health team, the youth's mental health therapist may not be trained to coach adults in behaviors that foster attachment. Attachment figures should be coached to frequently reach out to youth, tell the youth that the youth is in the adult's thoughts throughout the day, and ask the youth about particular events in the youth's life. For example, an adult may say "You were looking forwards to spending time with Amy last night, were you able to catch up with her? What did the two of you do?" or "I was thinking of you this morning when you were taking your math test, how did you feel about it? I know you studied hard." Adults can foster attachment by learning to listen to youth and validate the youth's emotions. This can be a difficult skill to learn and may require coaching from the CWW. Adults are often uncomfortable when youth share negative *emotions and often respond by trying to minimize the youth's distress. Instead, adults can help*

youth by validating the youth's emotions and listening to the youth describe problems. Even when adults are concerned with a youth's response to a negative emotion, the adult can still validate the youth's emotion. For example, "It sounds like your teacher spoke to you in a harsh tone today and you felt very disrespected." Coaching the adults in the youth's life can lead to a significant improvement in the attachments.

CWWs can also be attachment resources. Youth respond best when CWWs are good listeners, genuine, kind, warm, funny, honest, trustworthy, consistent, and available (Lindahl & Bruhn, 2015; Morrison, 2016).

Youth also have a great need and a right to be treated with respect (Brennan & Noggle 1997). Interventions must be presented in a way that highlights the youth's strengths and is not blaming or stigmatizing (Barnes, 2007). One of the most effective ways for CWWs to demonstrate respect is to closely listen to youth. This is often difficult when youth are engaged in dangerous behaviors. CWWs who fear for a youth's safety often respond by lecturing about the dangers of DMST. CWWs who chose social work as a profession because they want to help youth predictably become frustrated with youth who do not accept help or continue to engage in risky behavior (Schwartz et al., 2015). Notes from CWWs working with this population frequently include comments such as "I told the youth why it is so dangerous to run away". While well-intentioned, youth often experience these lectures as disrespectful. CWWs should instead focus on listening to what the youth are saying, and validating the youth's emotions. Ask youth what the adults can do to help them tolerate negative emotions. Praise efforts to tolerate negative emotions. In addition, CWWs and other adults should focus on a youth's strengths. Youth must hear that adults notice their strengths, value, and potential.

CWWs are obligated to provide opportunities for youth to develop autonomy. Adolescents will only develop into autonomous adults if they have frequent opportunities to verbalize their opinions and make choices. It is important for CWWs to recognize that all youth have at least

partial autonomy. This includes youth who have been victimized by early life experiences and DMST continue to have some agency over their lives (Olender 2019; Rozas, Ostrander & Feely, 2018). Even when youth admit to the dangers of DMST they often believe that a locked facility is more detrimental than continuing to engage in DMST. Engagement in DMST offers youth an opportunity to provide for their immediate needs and may provide youth with a sense of power that has often been absent from their experience (Dewey, 2014). Taking this power away without giving youth other opportunities to take control over their lives will likely be met with resistance.

Youth may be unable to make safe decisions but it is still important to inquire about the youth's thoughts, feelings, and emotions. Youth should be encouraged to think about both what they want in their current situation and in the future. Collaborative problem solving is a good model for talking with youth. In this model, youth can contribute to problem-solving with the CWW. The CWW can work with the youth to agree on the problem. The CWW and youth might agree on safety as a goal, yet the youth may not believe that staying out past curfew is dangerous. The youth may then be able to talk about times when he or she has not been safe, and develop a safety plan. During collaborative problem solving, the CWW can talk about what is and is not feasible from the worker's point of view.

Youth should also be encouraged to verbalize preferences as to who they contact from their biological family, what type of placement they prefer, extracurricular interests, and what type of mental health treatment they prefer. Foster parents should be coached to offer youth developmentally appropriate opportunities. For example, youth could be allowed to pick out some decorations for their bedroom, choose the dinner menu once a week, or suggest a movie that the family can watch together. Youth can also be included in discussions to determine house rules, including what would be a fair curfew, where youth are allowed to visit on school nights, and how household members should treat one another. After an adolescent does make

a choice, the CWW should celebrate the accomplishments and help the youth tolerate the setbacks that result from those choices.

Conclusion

CWWs are well aware of the risks to youth who are involved in DMST. Acknowledging the risks and disadvantages of RTCs forces CWWs to accept that no placement option provides the youth with a satisfactory level of personal security or well-being. Fortunately, this uncomfortable truth does not necessitate despair. A full understanding of the concept of well-being and autonomy development offers CWWs ample opportunities to intervene to the benefit of the youth in their care. If a youth must be admitted to an RTC, an understanding of the risk for abuse within an RTC can lead to proactive actions by the CWW to prevent abuse. CWWs should advocate for appropriate mental health treatment by encouraging positive attachments through frequent phone calls and visits with family members and facilitating family therapy, holding staff accountable for treating youth with respect, and urging the RTC to develop opportunities for the youth to practice autonomy. When youth stay in the community, CWWs should not throw up their hands, believing that there is nothing they can do to keep youth safe. With every interaction, CWWs can work with youth to develop a safety plan and discuss how the youth can implement that plan. CWWs should also offer youth opportunities to seek health and mental health care, finding providers that can be available on short notice whenever the youth is receptive to services. Additionally, CWWs can encourage attachment to family members, including coaching the family on the importance of attachment and ways to improve relationships. Of course, CWWs should always listen to youth and treat them with respect. Finally, CWWs should be intentional in efforts to facilitate the development of autonomy in youth under their care. Understanding the core dimensions of well-being offers CWWs tools that provide a pathway to a bright future for youth caught in the destructive web of DMST.

References

Abrams, K., 1999. From Autonomy to Agency: A Feminist Perspective on Self-Direction. William and Mary Law Review 40, 805-846.

Armaline, W.T., 2005. "Kids Need Structure": Negotiating Rules, Power, and Social Control in an Emergency Youth Shelter. Am. Behav. Sci. 48, 1124-1148.

Associated Press, 2021. Youth Center Closes Employee Arrests. US News.

Barnes, V., 2007. Young People's Views of Children's Rights and Advocacy Services: A Case for 'Caring' Advocacy? Child Abuse Review 16, 140-152.

Barnett, S., 2020. Foster care youth and the development of autonomy. Int Rev Psychiatry.

Barth, R.P., 2002. Institutions vs. Foster Homes: The Emperical Base for a Century of Action.

Bounds, D., Julion, W.A., Delaney, K.R., 2015. Comercial Sexual Exploitation of Children and State Child Welfare Systems. Policy, Policies, & Nursing Practice 0, 1-10.

Bradshaw, C.P., Rebok, G.W., Zablotsky, B., LaFlair, L.N., Mendelson, T., Eaton, W.W., 2012. Models of Stress and Adapting to Risk: A Life Course, Developmental Perspective, in Eaton, W.W. (Ed.), Public Mental Health. Oxford Scholarship Online.

Brennan, S., Noggle, R., 1997. The moral status of children: Children's rights, parents' rights, and family justice. Social Theory and Practice 23, 1-26.

Camp, D., 2014. Preventing Sex Trafficking and Strengthening Families Act.

Cecchet, S.A., Thoburn, J., 2014. The psychological experience of child and adolescent sex trafficking in the United States: Trauma and resilience in survivors. Psychological Trauma: Theory, Research, Practice, and Policy 6, 482-493.

Center for Disease Control and Prevention, 2018. Health-Related Quality of Life (HRQOL). 2021.

Child Welfare Information Gateway, 2020. Foster Care Statistics 2018. , 1-12.

Converse, B.A., Juarez, L., Hennecke, M., 2019. Self-control and the reasons behind our goals. J. Pers. Soc. Psychol. 116, 860-883.

Cuthbert, R., St. Pierre, J., Stewart, S.L., Cook, S., Johnson, A.M., Leschied, A.W., 2011. Symptom persistence in seriously emotionally disordered children: Findings of a two-year follow-up after residential treatment. Child Youth Care Forum 40, 267-280.

Czerwińska-Jasiewicz, M., 2017. The creation of a concept of one’s own life by adolescents as a manifestation of subjectivity and autonomy. Polish Psychological Bulletin 48, 28-37.

Dewey, S.C., 2014. Recovery Narratives, War Stories, and Nostalgia: Street-Based Sex Workers' Discursive Negotiations of the Exclusionary Regime. Anthropological Quarterly 87, 1137-1163.

Diaz, A., Arden, M., Blaustein, S., Nucci-Sack, A., Sanders, L., Steever, J., 2020. Featured counter trafficking program: Mount Sinai Adolescent Health Center. Child Abuse Negl. 100.

Ehring, T., Quack, D., 2010. Emotion regulation difficulties in trauma survivors: The role of trauma type and ptsd symptom severity. Behav Ther 41, 587-598.

Embry, L.E., Vander Stoep, A., Evens, C., Ryan, K.D., Pollock, A., 2000. Risk factors for homelessness in adolescents released from psychiatric residential treatment. Journal of the American Academy of Child & Adolescent Psychiatry 39, 1293-1299.

Engster, D., 2010. The Place of Parenting within a Liberal Theory of Justice: The Private Parenting Model, Parental Licenses, or Public Parenting Support? Social Theory and Practice 36, 233-262.

Faden, R., Powers, Madison, 2006. Social Justice, Inequality, and Systematic Disadvantage, in Faden, R., Powers, M. (Eds.), Social Justice: The Moral Foundations of Public Health and Health Policy. Oxford University Press, New York, pp. 582-590.

Farmer, E.M.Z., Wagner, H.R., Burns, B.J., Murray, M., 2016. Who goes where? Exploring factors related to placement among group homes. J Emot Behav Disord 24, 54-63.

Fong, R., Berger-Cardoso, J., 2010. Child human trafficking victims: Challenges for the child welfare system. Evaluation and Program Planning 33, 311-316.

Gewirtz O'Brien, J.R., Moynihan, M., Saewyc, E., Edinburgh, L.D., 2020. Featured counter-trafficking program: The Minnesota Runaway Intervention Program. Child Abuse Negl. 100.

Hair, H.J., 2005. Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. J. Child Fam. Stud. 14, 551-575.

Holland, S., 2010. Looked after children and the ethic of care. Br. J. Soc. Work 40, 1664-1680.

Huefner, J.C., Pick, R.M., Smith, G.L., Stevens, A.L., Mason, W.A., 2015. Parental involvement in residential care: Distance, frequency of contact, and youth outcomes. J. Child Fam. Stud. 24, 1481-1489.

Huefner, J.C., Vollmer, D.G., 2014. Characteristics and treatment needs of preadolescent versus adolescent children in an intensive residential treatment program. Resid Treat Child Youth 31, 301-315.

Jankowska, A.M., Lewandowska-Walter, A., Chalupa, A.A., Jonak, J., Duszynski, R., Mazurkiewicz, N., Understanding the Relationships Between Attachment
Styles, Locus of Control, School Maladaptation, and
Depression Symptoms Among Students in Foster Care. School Psychologist Forum: Research in Practice 9, 44-58.

Kim, J., Cicchetti, D., 2010. Longitudinal pathways linking child maltreatment, emotion regulation, peer relations, and psychopathology. J. Child Psychol. Psychiatry 51, 706-716.

Kobau, R., Sniezek, J., Zack, M.M., Lucas, R.E., Burns, A., 2010. Well-Being Assessment: An Evaluation of Well-Being Scales for Public Health and Population Estimates of Well-Being among US Adults. Applied Psychology: Health and Well-being 2, 272-297.

Ladd, S.K., Weaver, L.N., 2018. Moving Forward: Collaborative Accompaniment of Human Trafficking Survivors by Using Trauma-informed Practices. Journal of Human Trafficking 4, 191-212.

Landers, M., McGrath, K., Johnson, M.H., Armstrong, M.I., Dollard, N., 2017. Baseline characteristics of dependent youth who have been commercially sexually exploited: Findings from a specialized treatment program. J Child Sex Abus 26, 692-709.

Lee, B.R., Munson, M.R., Ware, N.C., Ollie, M.T., Scott, L.D.J., McMillen, J.C., 2006. Experiences of and attitudes toward mental health services among older youths in foster care. Psychiatr. Serv. 57, 487-492.

Leeson, C., 2007. My life in care: experiences of non-participation in decision-making processes. Child and Family Social Work 12, 268-277.

Leichtman, M., Leichtman, M.L., Barber, C.C., Neese, D.T., 2001. Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. Am. J. Orthopsychiatry 71, 227-235.

Lindahl, R., Bruhn, A., 2017. Foster children's experiences and expectations concerning the child-welfare officer role—Prerequisites and obstacles for close and trustful relationships. Child Fam. Soc. Work 22, 1415-1422.

Lyons, J.S., Terry, P., Martinovich, Z., Peterson, J., Bouska, B., 2001. Outcome trajectories for adolescents in residential treatment: A statewide evaluation. J. Child Fam. Stud. 10, 333-345.

Malin, H., Liauw, I., Damon, W., 2017. Purpose and Character Development in Early Adolescence. Journal of Youth and Adolescence 46, 1200-1215.

McElhaney, K.B., Allen, J.P., Stephenson, J.C., Hare, A.L., 2009. Attachment and autonomy during adolescence, in Lerner, R.M., Steinberg, L. (Eds.). John Wiley & Sons Inc, Hoboken, NJ, pp. 358-403.

Minow, M., Shanley, M.L., 1996. Relational rights and responsibilities: Revisioning the family in liberal political theory and law. Hypatia 11, 4.

Miranda, M., Molla, E., Tadros, E., 2019. Implications of foster care on attachment: A literature review. Fam J Alex Va 27, 394-403.

Mooney, H.E., 2021. Activists, state authorities and lawsuits filed by survivors are putting pressure on the 'troubled teens' industry to change its ways. The Conversation.

Morris, A.S., Silk, J.S., Steinberg, L., Myers, S.S., Robinson, L.R., 2007a. The role of the family context in the development of emotion regulation. Soc Dev 16, 361-388.

Morris, A.S., Silk, J.S., Steinberg, L., Myers, S.S., Robinson, L.R., 2007b. The role of the family context in the development of emotion regulation. Soc Dev 16, 361-388.

Morrison, S., 2016. In care, aftercare and caring for those in care: My successful care journey. Child Care in Practice 22, 113-127.

Mullin, A., 2014. Children, Paternalism and the Development of Autonomy. Ethical Theory and Moral Practice 17, 413-426.

Naccarato, T., DeLorenzo, E., 2008. Transitional Youth Services: Practice Implications from a Systematic Review. 25, 287-308.

Niemiec, C.P., Ryan, R.M., Deci, E.L., 2010. Self-determination theory and the relation of autonomy to self-regulatory processes and personality development, in Hoyle, R.H. (Ed.). Wiley-Blackwell, pp. 169-191.

O'Brien, J.E., White, K., Rizo, C.F., 2017. Domestic minor sex trafficking among child welfare–involved youth: An exploratory study of correlates. Child Maltreat. 22, 265-274.

Olender, S., 2019. Combatting Domestic Minor Sex Trafficking in the Child Welfare System. Kennedy School Review: A Harvard Kennedy School Student Publication.

Palines, P.A., Rabbitt, A.L., Pan, A.Y., Nugent, M.L., Ehrman, W.G., 2020. Comparing mental health disorders among sex trafficked children and three groups of youth at high-risk for trafficking: A dual retrospective cohort and scoping review. Child Abuse Negl. 100.

Parra, A., Oliva, A., 2009. A longitudinal research on the development of emotional autonomy during adolescence. Span J Psychol 12, 66-75.

Peterson, K.A., Zhoe, L., Watzlaf, V.J.M., 2019. A Comprehensive Review of Quality of Life Surveys for Trauma-Affected Communities. Perspect Health Inf Manag 16.

Pfeifer, J.H., Berkman, E.T., 2018. The development of self and identity in adolescence: Neural evidence and implications for a value-based choice perspective on motivated behavior. Child Dev Perspect.

Philosophicaltherapist, 2017. Understanding Personal Agency.

Polaris, 2015. Sex Trafficking in the U.S.: A Closer Look at U.S. Citizen Victims.

Polkki, P., Vornanen, R., Pursiainen, M., Riikonen, M., 2012. Children's Participation in Child-Protection Processes as Experienced by Foster Children and Social Workers. Child Care in Practice 18, 107-125.

Pope, L.G., 2015. To Forgive and Discredit: Bipolar Identities and Medicated Selves Among Female Youth in Residential Treatment. Cult. Med. Psychiatry 39, 505-531.

Raghavan, R., Alexandrova, A., 2015. Toward a Theory of Child Well-Being. Soc Indic Res 121, 887-902.

Roberts, L.W., Geppert, C.M.A., Bailey, R., 2002. Ethics in psychiatric practice: Essential ethics skills, informed consent, the therapeutic relationship, and confidentiality. J Psychiatr Pract 8, 290-305.

Rome, S.H., Raskin, M., 2019. Transitioning Out of Foster Care: The First 12 Months. Youth & Society 51, 529-547.

Rozas, L.W., Ostrander, J., Feely, M., 2018. Inequalities in US Child Protection: The Case of Sex Trafficked Youth. 7, 135.

Schechter, D.S., Willheim, E., 2009. Disturbances of attachment and parental psychopathology in early childhood. Child Adolesc. Psychiatr. Clin. N. Am. 18, 665-686.

Schofield, G., 2005. The Voice of the Child in Family Placement Decision-Making: A Developmental Model. Adoption and Fostering 29, 29-44.

Schofield, G., Beek, M., 2005. Providing a secure base: Parenting children in long-term foster family care. Attach Hum Dev 7, 3-25.

Schwarz, C., Britton, H.E., 2015. Queering the Support for Trafficked Persons: LGBTQ Communities and Human Trafficking in the Heartland. Social Inclusion 3, n/a.

Shapiro, J.P., Welker, C.J., Pierce, J.L., 1999. An evaluation of residential treatment for youth with mental health and delinquency-related problems. Residential Treat. Child. Youth 17, 33-48.

Singer, E., Doornenbal, J., Okma, K., 2004. Why Do Children Resist or Obey Their Foster Parents? The Inner Logic of Children's Behavior During Discipline. Child Welfare: Journal of Policy, Practice, and Program 83, 581-610.

Smith, C., 2008. Victims of Trafficking and Violence Protection Act of 2000.

Soenens, B., Vansteenkiste, M., 2005. Antecedents and outcomes of self-determination in 3 life domains: The role of parents' and teachers' autonomy support. Journal of Youth and Adolescence 34, 589-604.

Sokol, B.W., Hammond, S.I., Kuebli, J., Sweetman, L., 2015. The Development of Agency, in Lerner, R.M., Molenaar, P., Overton, W.F. (Eds.), Handbood of Child Psychology and Developmental Science Volume 1, Theory and Method. John Wiley & Sons.

Spear, H.J., Kulbok, P., 2004. Autonomy and Adolescence: A Concept Analysis. Public Health Nurs. 21, 144-152.

Stanley, E., 2016. Silencing Violations in State Care. New Zealand Sociology 31, 9-30.

Strassburger, Z., 2016. Medical Decision Making for Youth in the Foster Care System. J. Marshall L. Rev. 49, 1103-1154.

Todres, J., Clayton, E.W., 2014. Responding to the Sexual Exploitation of Minors. New England Journal of Medicine 370, 1282-1283.

United States Government Accountability Office, 2007. Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth.

US Department of State, 2016. Trafficking in persons report .

Varma, S., Gillespie, S., McCracken, C., Greenbaum, V.J., 2015. Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. Child Abuse & Neglect 44, 98-105.

Walker, K., Quraishi, F., 2014. From Abused and Neglected to Abused and Exploited: The Intersection Between the Child Welfare System and Child Sex Trafficking. National Center for Youth Law .

Welch, K.E., 2020. Featured counter-trafficking program: RELENTLESS. Child Abuse Negl. 100.

WestCoast Children's Clinic, 2012. Research to Action: Sexually Exploited Minors (SEM) Needs and Strenghts.

Wulczyn, F., Parolini, A., Huhr, S., 2018. Human Capital, Child Well-being, and Child Protection. 2021.

Zimmerman, B.J., Cleary, T.J., 2006. Adolescents' Development of Personal Agency. The Role of Self-efficacy Beliefs and Self-Regulatory Skills, in Pajares, F., Urdan, T. (Eds.), Self-Efficacy Beliefs of Adolescents. Information Age Publishing, pp. 45-70.